FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044164

Facility Name: CRESTWOOD CARE CENTRE

Address: 14255 S. CICERO AVE. (Number) CRESTWOOD (City) 60445 (Zip Code)

County: COOK

Telephone Number: (708) 371-0400 **Fax #** (708) 371-5871

IDPA ID Number: 36-3967295

Date of Initial License for Current Owners: 08/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	303	Skilled (SNF)	303	110,898	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	303	TOTALS	303	110,898	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,427	2,293	18,315	40,035	8
9	SNF/PED					9
10	ICF	45,329	4,950	5,369	55,648	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,756	7,243	23,684	95,683	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.28%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 303 and days of care provided 12,192

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	480,266	46,411	22,973	549,650		549,650	(6,134)	543,516			1
2	Food Purchase		357,620		357,620		357,620	(1,620)	356,000			2
3	Housekeeping	314,753	47,562		362,315		362,315	(2,576)	359,739			3
4	Laundry	136,003	34,731	12,548	183,282		183,282	(1,041)	182,241			4
5	Heat and Other Utilities			197,581	197,581		197,581		197,581			5
6	Maintenance	76,811	51,499	81,885	210,195		210,195	2,113	212,308			6
7	Other (specify):*			105,530	105,530		105,530		105,530			7
8	**TOTAL General Services**	1,007,833	537,823	420,517	1,966,173		1,966,173	(9,258)	1,956,915			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	3,979,162	274,527	155,980	4,409,669		4,409,669	(110,485)	4,299,184			10
10a	Therapy	96,113	161	1,263	97,537		97,537		97,537			10a
11	Activities	218,023	3,551	6,009	227,583		227,583	(647)	226,936			11
12	Social Services	183,918		2,858	186,776		186,776		186,776			12
13	Nurse Aide Training											13
14	Program Transportation			606	606		606		606			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,477,216	278,239	202,716	4,958,171		4,958,171	(111,132)	4,847,039			16
	C. General Administration											
17	Administrative	187,379		1,251,359	1,438,738		1,438,738	(1,214,010)	224,728			17
18	Directors Fees											18
19	Professional Services			515,314	515,314		515,314	(311,254)	204,060			19
20	Dues, Fees, Subscriptions & Promotions			97,760	97,760		97,760	(68,847)	28,913			20
21	Clerical & General Office Expenses	351,076	64,868	85,208	501,152		501,152	228,897	730,049			21
22	Employee Benefits & Payroll Taxes			1,118,054	1,118,054		1,118,054		1,118,054			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,758	8,758		8,758	16,378	25,136			24
25	Other Admin. Staff Transportation			11,058	11,058		11,058		11,058			25
26	Insurance-Prop.Liab.Malpractice			375,433	375,433		375,433	33,006	408,439			26
27	Other (specify):*			120,693	120,693		120,693	(120,693)				27
28	**TOTAL General Administration**	538,455	64,868	3,583,637	4,186,960		4,186,960	(1,436,523)	2,750,437			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,023,504	880,930	4,206,870	11,111,304		11,111,304	(1,556,913)	9,554,391			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CRESTWOOD CARE CENTRE #0044164 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	21,558	
	REPAIRS & MAINTENANCE		1,415	
			0	22,973
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		12,548	
			0	12,548
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		91,024	
	ELECTRICITY		87,386	
	WATER		19,171	
	CABLE TV - LOBBY		0	
			0	197,581
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		8,978	
	PAINTING & DECORATING		1,390	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		43,638	
	ELEVATOR MAINTENANCE & REPAIR		11,244	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,402	
	FIRE SERVICE		11,233	
			0	
			0	
			0	81,885
7	**OTHER**			
	SCAVENGER		32,570	
	SECURITY SERVICE		72,960	105,530
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	36,000	36,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,147	
	PHARMACY CONSULTANT	XVIII B 39-2	3,300	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B 46-2	5,000	
	RN CONSULTANT	XVIII B 38-2	137,583	
	WOUND CARE CONSULTANT	XVIII B 47-2	7,950	
			0	155,980
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		618	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		645	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,263
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		2,304	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,705	
			0	6,009
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,858	
			0	2,858
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CRESTWOOD CARE CENTRE **#0044164** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		606	606
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	1,251,359	1,251,359
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	33,962	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	481,352	
			0	515,314
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	31,809	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,650	
	EMPLOYEE WANT ADS	XIX F	7,143	
	CONTRIBUTIONS	VI 20 XIX F	345	
	DUES & SUBSCRIPTIONS	XIX F	12,932	
	LICENSES & PERMITS	XIX F	3,809	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	17,267	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	9,336	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,469	97,760
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,980	
	EQUIPMENT REPAIR & MAINTENANCE		14,845	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	51	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		61,247	
	MESSENGER SERVICE		2,085	
			0	85,208

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	454,471	
	UNEMPLOYMENT COMPENSATION	XIX D	81,239	
	WORKERS COMPENSATION INSURANCI	XIX D	125,440	
	HOSPITALIZATION INSURANCE	XIX D	445,047	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,449	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	8,408	
	CHICAGO HEAD TAX	XIX D	0	1,118,054
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	8,418	
	TRAVEL	XIX G	340	
			0	
			0	8,758
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		11,058	11,058
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		375,433	375,433
27	**OTHER**			
	BAD DEBTS	VI 24	120,693	
				120,693

GRAND TOTAL COLUMN 3 OTHER 4,206,870

CRESTWOOD CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	357,620	PATIENT MEALS	287049
LESS SALES TAX	(1,620)	ADD EMPLOYEE MEALS	0
NET FOOD	356,000	TOTAL MEALS/YEAR	287049
TOTAL PATIENT CENSUS	95,683	NET FOOD	356000
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	287049
TOTAL PATIENT MEALS	287049	COST PER MEAL	1.24
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number CRESTWOOD CARE CENTRE #0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			136,299	136,299		136,299	154,514	290,813			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,593	134,593		134,593	260,222	394,815			32
33	Real Estate Taxes			480,974	480,974		480,974		480,974			33
34	Rent-Facility & Grounds			1,182,600	1,182,600		1,182,600	(1,125,434)	57,166			34
35	Rent-Equipment & Vehicles			57,668	57,668		57,668	12,880	70,548			35
36	Other (specify):* STORAGE			6,056	6,056		6,056		6,056			36
37	**TOTAL Ownership**			1,998,190	1,998,190		1,998,190	(697,818)	1,300,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		424,080	1,309,659	1,733,739		1,733,739		1,733,739			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,348	166,348		166,348		166,348			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		424,080	1,476,007	1,900,087		1,900,087		1,900,087			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,023,504	1,305,010	7,681,067	15,009,581		15,009,581	(2,254,731)	12,754,850			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26,118)	30		9
10	Interest and Other Investment Income	(2,077)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,620)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(51)	21		18
19	Entertainment	(31,809)	20		19
20	Contributions	(9,681)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(15,115)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(120,693)	27		24
25	Fund Raising, Advertising and Promotional	(11,650)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(17,267)	20		28
29	Other-Attach Schedule	(63,070)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (299,151)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,955,580)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,955,580)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,254,731)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CRESTWOOD CARE CENTRE

ID# 0044164

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2237	6	1
2	VACATION ACCRUAL	(6,134)	1	2
3	VACATION ACCRUAL	(2,576)	3	3
4	VACATION ACCRUAL	(1,041)	4	4
5	VACATION ACCRUAL	(124)	6	5
6	VACATION ACCRUAL	(41,193)	10	6
7	VACATION ACCRUAL	(647)	11	7
8	VACATION ACCRUAL	(13,592)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(63,070)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(6,134)	0	0	0	0	0	0	0	0	0	0	(6,134)	1
2	Food Purchase	(1,620)	0	0	0	0	0	0	0	0	0	0	(1,620)	2
3	Housekeeping	(2,576)	0	0	0	0	0	0	0	0	0	0	(2,576)	3
4	Laundry	(1,041)	0	0	0	0	0	0	0	0	0	0	(1,041)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,113	0	0	0	0	0	0	0	0	0	0	2,113	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(9,258)	0	0	0	0	0	0	0	0	0	0	(9,258)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(41,193)	0	(31,943)	0	(37,349)	0	0	0	0	0	0	(110,485)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(647)	0	0	0	0	0	0	0	0	0	0	(647)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(41,840)	0	(31,943)	0	(37,349)	0	0	0	0	0	0	(111,132)	16
	C. General Administration													
17	Administrative	0	0	(571,293)	(482,038)	0	0	(160,679)	0	0	0	0	(1,214,010)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(15,115)	8,750	(127,653)	68,957	976	(247,169)	0	0	0	0	0	(311,254)	19
20	Fees, Subscriptions & Promotions	(70,407)	0	875	268	29	388	0	0	0	0	0	(68,847)	20
21	Clerical & General Office Expenses	(13,643)	81	85,399	456	2,096	154,508	0	0	0	0	0	228,897	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,676	826	3,885	3,991	0	0	0	0	0	16,378	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	23,427	3,805	644	2,390	2,740	0	0	0	0	0	33,006	26
27	Other (specify):*	(120,693)	0	0	0	0	0	0	0	0	0	0	(120,693)	27
28	TOTAL General Administration	(219,858)	32,258	(601,191)	(410,887)	9,376	(85,542)	(160,679)	0	0	0	0	(1,436,523)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(270,956)	32,258	(633,134)	(410,887)	(27,973)	(85,542)	(160,679)	0	0	0	0	(1,556,913)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(26,118)	169,476	5,676	0	190	5,290	0	0	0	0	0	154,514	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,077)	262,299	0	0	0	0	0	0	0	0	0	260,222	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,182,600)	24,673	0	1,683	30,810	0	0	0	0	0	(1,125,434)	34
35	Rent-Equipment & Vehicles	0	0	6,262	792	2,677	3,149	0	0	0	0	0	12,880	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,195)	(750,825)	36,611	792	4,550	39,249	0	0	0	0	0	(697,818)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(299,151)	(718,567)	(596,523)	(410,095)	(23,423)	(46,293)	(160,679)	0	0	0	0	(2,254,731)	45

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED		CRESTWOOD HEIGHTS NURSING HOME		
		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,182,600	CRESTWOOD HEIGHTS NURSING CENTRE		$	$ (1,182,600)	1
2	V	19	ACCOUNTING FEES		" "		8,500	8,500	2
3	V	26	MORTGAGE INSURANCE		" "		23,427	23,427	3
4	V	30	DEPRECIATION - BLDG IMP		" "		168,884	168,884	4
5	V	30	DEPRECIATION-EQPT & FURN		" "		592	592	5
6	V	32	AMORTIZATION - MTG COST		" "		1,342	1,342	6
7	V	32	MORTGAGE INTEREST		" "		260,957	260,957	7
8	V	19	DATA PROCESSING		" "				8
9	V	19	PROFESSIONAL FEES		" "		250	250	9
10	V	21	OFFICE EXPENSES		" "		81	81	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,182,600			$ 464,033	$ * (718,567)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 40,961	FHC ENTERPRISES, INC.		$ 9,018	$ (31,943)	15
16	V	17	ADMINISTRATIVE	608,642	MR. BELLOWS OWNS 21% OF THIS FACILITY		37,349	(571,293)	16
17	V	19	PROFESSIONAL FEES	128,179	AND 100% OF FHC ENTERPRISES		526	(127,653)	17
18	V	20	DUES & SUBSCRIPTIONS		" "		875	875	18
19	V	21	CLERICAL		" "		85,399	85,399	19
20	V	24	TRAVEL		" "		7,676	7,676	20
21	V	26	INSURANCE		" "		3,805	3,805	21
22	V	30	DEPRECIATION		" "		5,676	5,676	22
23	V	34	RENT				24,673	24,673	23
24	V	35	RENT - EQPT & VEH				6,262	6,262	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 777,782			$ 181,259	$ * (596,523)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCCIATES, LLC		$ 68,957	$ 68,957	15
16	V	20	DUES & SUBSCRIPTIONS		" "		268	268	16
17	V	21	CLERICAL		" "		456	456	17
18	V	24	TRAVEL		" "		826	826	18
19	V	26	INSURANCE		" "		644	644	19
20	V	35	RENT-EQUIPMENT & VEH		" "		792	792	20
21	V	17	ADMINISTRATIVE	482,038	" "			(482,038)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 482,038			$ 71,943	$ * (410,095)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 96,617	CARLYLE NURSING ASSOCIATES, LLC		$ 59,268	$ (37,349)	15
16	V	19	PROFESSIONAL FEES		" "		976	976	16
17	V	20	DUES & SUBSCRIPTIONS		" "		29	29	17
18	V	21	CLERICAL		" "		2,096	2,096	18
19	V	24	TRAVEL		" "		3,885	3,885	19
20	V	26	INSURANCE		" "		2,390	2,390	20
21	V	30	DEPRECIATION		" "		190	190	21
22	V	34	RENT		" "		1,683	1,683	22
23	V	35	RENT-EQPT & VEH		" "		2,677	2,677	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,617			$ 73,194	$ * (23,423)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 255,273	THE KENSINGTON GROUP, LLC		$ 8,104	$ (247,169)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		388	388	16
17	V	21	CLERICAL		" "		154,508	154,508	17
18	V	24	TRAVEL		" "		3,991	3,991	18
19	V	26	INSURANCE		" "		2,740	2,740	19
20	V	30	DEPRECIATION		" "		5,290	5,290	20
21	V	34	RENT		" "		30,810	30,810	21
22	V	35	RENT - EQPT & VEH		" "		3,149	3,149	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 255,273			$ 208,980	$ * (46,293)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 160,679	CHESTERFIELD, LLC		$	$ (160,679)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 160,679			$ 0	$ * (160,679)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES, INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	0.22	SEE ATTACHED	0.48	3.12	SALARY	37,349	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 37,349		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	$ 46,961	$ 46,961	47,053	$ 9,018	1
2	17	ADMINISTRATIVE	DIRENT COST	1	1	37,349	37,349	1	37,349	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739		47,053	526	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554		47,053	875	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460		47,053	19,099	5
6	21	CLERICAL	DIRECT COST	1	1	66,300	66,300	1	66,300	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971		47,053	7,676	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813		47,053	3,805	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557		47,053	5,676	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484		47,053	24,673	10
11	35	RENT - EQUIPMENT & VEH	PATIENT DAYS	245,034	9	32,607		47,053	6,262	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 507,795	$ 150,610		$ 181,259	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTONG GROVE, IL 60053
Phone Number: (847) 583-0053
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	150,271	5	$ 213,094	$	48,631	$ 68,957	1
2	20	DUES & SUBSCRIPTONS	PATIENT DAYS	150,271	5	829		48,631	268	2
3	21	CLERICAL	PATIENT DAYS	150,271	5	1,408		48,631	456	3
4	24	TRAVEL	PATIENT DAYS	150,271	5	2,553		48,631	826	4
5	26	INSURANCE	PATIENT DAYS	150,271	5	1,990		48,631	644	5
6	35	RENT-EQPT & VEH	PATIENT DAYS	150,271	5	2,448		48,631	792	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 222,322	$		$ 71,943	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	$ 285,631	$ 285,631	48,631	$ 59,268	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705		48,631	976	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142		48,631	29	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102		48,631	2,096	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724		48,631	3,885	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520		48,631	2,390	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917		48,631	190	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109		48,631	1,683	8
9	35	RENT-EQPT & VEH	PATIENT DAYS	234,229	9	12,901		48,631	2,677	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 352,751	$ 285,631		$ 73,194	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINGTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	$ 39,055	$	48,631	$ 8,104	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	1,870		48,631	388	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,608	660,461	48,631	154,508	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234		48,631	3,991	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205		48,631	2,740	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492		48,631	5,290	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483		48,631	30,810	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176		48,631	3,149	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,007,123	$ 660,461		$ 208,980	25

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$101,139.93	12/03	4,897,900	4,853,057	12/38	0.0535	260,957	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		54,329	46,983			1,342	3
4												4
5												5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	DEMAND	VARIES	323,671	1,433,000	DEMAND	PRIME+	62,655	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	1,191,428	1,741,681	DEMAND	VARIES	59,675	7
8	PARTNERS LOANS	X		WORKING CAPITAL	DEMAND	12/31/99	100,000	160,904	DEMAND	8.2500	12,263	8
9	TOTAL Facility Related				$101,139.93		$ 6,567,328	$ 8,235,625			$ 396,892	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,567,328	$ 8,235,625			$ 396,892	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 456,606	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 467,330	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,724	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 470,250	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 480,974	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	471,970	8
	2000	450,237	9
	2001	467,362	10
	2002	471,212	11
	2003	467,330	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CRESTWOOD CARE CENTRE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044164

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	28-03-303-011-0000	NURSING HOME	$ 163,666.77	$ 163,666.77
2.	28-03-303-012-0000	NURSING HOME	$ 297,931.03	$ 297,931.03
3.	28-03-303-038-0000	NURSING HOME	$ 5,732.67	$ 5,732.67
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 467,330.47	$ 467,330.47

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,960 B. General Construction Type: Exterior STONE Frame STEEL Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,000	1972	$ 294,389	1
2	SEWER		1978	41,363	2
3	TOTALS	75,000		$ 335,752	3

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	303		1974		$ 2,091,708	$ 26,548	35	$ 59,763	$ 33,215	$ 1,847,673	4
5			1980		3,400		35	100	100	2,450	5
6	SEC 754 AJ			1992	584,054	21,238	31.5	18,541	(2,697)	231,765	6
7	SEC 754 AJ			2001	24,100	876	27.5	876		3,504	7
8											8
	Improvement Type**										
9	RELATED PARTY - CRESTWOOD HEIGHTS NURSING CENTRE										9
10	REMODELING			1977	34,163		10			34,163	10
11	REMODELING			1980	12,383		10			12,383	11
12	IMPROVEMENTS			1984	38,466		20			38,466	12
13	IMPROVEMENTS			1985	18,271	326	10		(326)	18,271	13
14	IMPROVEMENTS			1985	1,200	60	20	60		1,170	14
15	IMPROVEMENTS			1985	32,506	1,302	15		(1,302)	32,506	15
16	IMPROVEMENTS			1986	76,557	3,982	20	3,828	(154)	70,812	16
17	IMPROVEMENTS			1986	16,943	881	10		(881)	16,943	17
18	IMPROVEMENTS			1986	1,559	81	25	62	(19)	1,147	18
19	IMPROVEMENTS			1987	23,951	855	20	1,198	343	20,956	19
20	IMPROVEMENTS			1987	22,863	831	20	1,143	312	20,003	20
21	IMPROVEMENTS			1988	20,627	1,530	20	1,031	(499)	12,850	21
22	IMPROVEMENTS			1989	35,057	484	31.5	1,113	629	17,631	22
23	IMPROVEMENTS			1990	50,320	1,830	31.5	1,598	(232)	22,710	23
24	IMPROVEMENTS			1991	53,090	1,931	31.5	1,684	(247)	22,450	24
25	IMPROVEMENTS			1992	53,668	1,952	31.5	1,704	(248)	21,332	25
26	IMPROVEMENTS			1992	51,711	3,447	31.5	3,447		42,657	26
27	IMPROVEMENTS			1993	42,479	1,545	15	1,090	(455)	12,290	27
28	IMPROVEMENTS			1993	78,601	2,858	39	2,495	(363)	29,360	28
29	IMPROVEMENTS			1994	193,211	7,026	27.5	7,026		69,265	29
30	FIRE ALARM SYSTEMS			1995	19,476	708	27.5	708		6,783	30
31	ELEVATOR REHAB			1995	57,000	2,072	27.5	2,072		19,334	31
32	NURSES CALL STATION			1995	6,318	230	27.5	230		2,145	32
33	DINING ROOM AIR CONDITIONING SYSTEM			1995	9,370	341	27.5	341		3,097	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	COOLING TOWER REPLACEMENT	1995	$ 15,650	$ 569	27.5	$ 569	$	$ 5,166	37
38	HANDRAILS/TILING ROOF	1996	103,547	3,765	27.5	3,765		32,305	38
39	HANDRAILS/TILING ROOF	1996	877	32	27.5	32		266	39
40	OUR TOWN	1996	61,800	2,247	27.5	2,247		17,595	40
41	REMODELING EXISTING STRUCTURE/SMOKE DOORS	1997	65,677	2,390	27.5	2,390		18,410	41
42	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1997	406,833	14,794	27.5	14,794		113,120	42
43	FIRE EXIT/REHAB/ROOF/OUR TOWN/WALLCOVERING	1997	44,213	1,607	27.5	1,607		12,099	43
44	WINDOW/OUR TOWN/WALLCOVERING/FLOORS	1997	76,586	2,784	27.5	2,784		20,464	44
45	OUR TOWN	1998	32,000	1,164	27.5	1,164		8,099	45
46	ELECTRICAL WIRING FOR LAUNDRY AREA	1998	4,400	160	27.5	160		1,113	46
47	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	35,000	1,273	27.5	1273		8,858	47
48	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	900	33	27.5	33		229	48
49	REMODELING-FLOOR/ENTRYWAYS/WALLS/WINDOWS	1998	9,604	349	27.5	349		2,429	49
50	AIR CONDITIONING SYSTEM	1998	17,900	651	27.5	651		4,421	50
51	ROOF REPAIRS	1998	2,790	101	27.5	101		686	51
52	BOILER VALVE	1998	5,450	198	27.5	198		1,196	52
53	WALLCOVERING	1999	2,206	80	27.5	80		547	53
54	METAL DOORS/OAK DOORS AND LOCKSETS	1999	6,267	228	27.5	228		1,186	54
55	OVERHANG WORK	1999	4,150	151	27.5	151		774	55
56	REMODEL - NURSES STATION	2000	25,135	914	27.5	914		4,151	56
57	A/C COMPRESSOR	2000	27,970	1,017	27.5	1,017		4,534	57
58	ROOF WORK	2000	11,384	414	27.5	414		1,777	58
59	REMODELING-DIALYSIS ROOM-PLUMBING, ELECTRICAI	2000	23,240	845	27.5	845		3,556	59
60	REMODEL - NURSES STATION	2000	10,730	390	27.5	390		1,609	60
61	CLOSET DOORS - 2,3, AND 4TH FLOOR NURSES STATION	2001	1,900	69	27.5	69		273	61
62	PAINT LOCKER ROOMS AND RESIDENT BATHROOMS	2001	1,050	38	27.5	38		147	62
63	RENOVATE - 3A, 4B AND 4A UTILITY ROOM CABINETS	2001	6,405	233	27.5	233		864	63
64	WANDERING ALERT SYSTEM - ALZHEIMERS UNIT	2001	17,525	637	27.5	637		2,309	64
65	DRYWALL AND PAINT ROOM 226 AND BATHROOM	2001	1,883	68	27.5	68		241	65
66	ANTENNA SYSTEMS	2001	16,745	609	27.5	609		2,106	66
67	WANDERING ALERT SYSTEM - FIRST FLOOR	2001	13,650	496	27.5	496		1,509	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,706,519	$ 121,240		$ 148,416	$ 27,176	$ 2,906,155	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,706,519	$ 121,240		$ 148,416	$ 27,176	$ 2,906,155	1
2	REPLACE FIRST FLOOR DOUBLE DOORS	2001	3,150	115	27.5	115		350	2
3	KITCHEN FLOOR - REMOVE OLD AND INSTALL NEW TILI	2002	3,086	112	27.5	112		322	3
4	REPLACE 49 DOORS AND 1ST AND 3RD FLR FIRE DOORS	2002	24,500	891	27.5	891		2,487	4
5	BUILD NEW SMOKING LOUNGE	2002	3,596	131	27.5	131		366	5
6	NEW CEILING GRIDS & WALLS FOR SMOKING LOUNGE	2002	3,292	120	27.5	120		335	6
7	INSTALL WALLCOVERING - ROOM 223	2002	1,800	65	27.5	65		182	7
8	REBUILD AND PREP WALLS - RMS 234, 334 AND LOUNGE	2002	4,000	145	27.5	145		393	8
9	INSTALL DRYWALL & SOFFITS IN BATHROOM IN RM 306	2002	1,500	55	27.5	55		144	9
10	INSTALL NEW TRANSFER SWITCH FOR GENERATOR	2002	15,139	550	27.5	550		1,352	10
11	FLAT ROOF REPAIRS - LEAKS BY COOLING TOWER	2002	2,169	79	27.5	79		194	11
12	PARKING LOT - COMPLETE RECONSTRUCTION	2002	2,195	80	27.5	80		190	12
13	PARKING LOT - COMPLETE RECONSTRUCTION	2002	114,136	4,150	27.5	4,150		9,165	13
14	CONSTRUCTION OF NEW ALZHEIMERS UNIT	2003	315,941	11,488	27.5	11,488		16,754	14
15	REPLACE 2ND & 3RD FLR. PATIENT DOORS, FIRE DOORS	2003	17,497	636	27.5	636		928	15
16	RESURFACE AND PAVE PARKING LOT	2003	3,697	247	15	247		370	16
17	ALUMINUM ROOF	2003	1,700	62	27.5	62		90	17
18	PAINTED & PREP 12 RSDNT RMS, BATH & LAUNDRY RMS	2003	9,250	336	27.5	336		490	18
19	FIRE DAMPERS	2004	3,417	56	27.5	56		56	19
20	INSTALLED A SOFTSTART	2004	2,670	44	27.5	44		44	20
21	AMEREX KP FIRE SUPPRESSION SYSTEM	2004	1,457	23	27.5	23		23	21
22	OAK FLUSH FIRE DOORS - DIETARY/BATH AND BED RMS	2004	7,632	126	27.5	126		126	22
23	REMOVE & INSTALL NEW SHAMPOO STATION & TOILET	2004	1,945	31	27.5	31		31	23
24	WATER SYSTEM	2004	16,254	270	27.5	270		270	24
25	REPLACE ENTRY WALK	2004	5,500	91	27.5	91		91	25
26	NEW PANASONIC TELEPHONE SYSTEM	2004	26,934	448	27.5	448		448	26
27	REMOVE & INSTALL WALLCOVERING - REHAB ROOM	2004	2,786	93	15	93		93	27
28	PATCH TO THE FIELD/WALL FLASHING - ROOF	2004	1,500	24	27.5	24		24	28
29									29
30			SL ADJ	27,176			(27,176)		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,303,262	$ 168,884		$ 168,884	$	$ 2,941,473	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,053,371	$ 66,828	$ 104,392	$ 37,564	3-10 YRS	$ 618,569	71
72	Current Year Purchases	115,785	69,471	5,789	(63,682)	3-10 YRS	5,789	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		11,748	11,748				74
75	TOTALS	$ 1,169,156	$ 148,047	$ 121,929	$ (26,118)		$ 624,358	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,808,170	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 316,931	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 290,813	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,118)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,565,831	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 37,655 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 JEEP CHEROKEE	$ 615.89	$ 6,775	17
18	FACILITY USE	2002 FORD CLUB WAG	675.97	8,249	18
19	ADMINISTRATIVE	2003 MAXIMA GLE	619.83	4,989	19
20					20
21	TOTAL		$ #######	$ 20,013	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 595,638	$		$ 595,638	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			77,666			77,666	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			634,650			634,650	4
5	Physician Care	39-3	visits			1,705			1,705	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				354,861		354,861	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify): MEDICAL SUPPLY	39-2					69,219		69,219	13
14	TOTAL			$		$ 1,309,659	$ 424,080		$ 1,733,739	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 259,262	$ 1,503,816	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 135,911)	3,409,278	3,409,278	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,738	193,334	6
7	Other Prepaid Expenses	54,238	65,187	7
8	Accounts Receivable (owners or related parties)	471,721	471,721	8
9	Other(specify): ESCROW DEPOSITS		525,613	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,278,237	$ 6,168,949	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		1,799,392	11
12	Long-Term Investments	2,811	2,811	12
13	Land		477,487	13
14	Buildings, at Historical Cost		2,095,108	14
15	Leasehold Improvements, at Historical Cost		2,600,002	15
16	Equipment, at Historical Cost	1,087,809	1,508,613	16
17	Accumulated Depreciation (book methods)	(955,929)	(3,631,721)	17
18	Deferred Charges	1,449	47,026	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONSTR. IN PROG		17,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 136,140	$ 4,916,218	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,414,377	$ 11,085,167	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 870,938	$ 897,207	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	372,809	372,809	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,523	73,523	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,711	18,711	31
32	Accrued Real Estate Taxes(Sch.IX-B)		470,250	32
33	Accrued Interest Payable		21,637	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO IDPA	27,901	27,901	36
37	DUE TO LESSOR	1,179,189		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,543,071	$ 1,882,038	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,335,585	3,335,585	39
40	Mortgage Payable		4,853,057	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,335,585	$ 8,188,642	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,878,656	$ 10,070,680	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,464,279)	$ 1,014,487	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,414,377	$ 11,085,167	48

*(See instructions.)

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,240,403)	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,240,402)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	776,123	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 776,123	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,464,279)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,784,064	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,784,064	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,077	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,077	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,786,141	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,966,173	31
32	Health Care	4,958,171	32
33	General Administration	4,186,960	33
	B. Capital Expense		
34	Ownership	1,998,190	34
	C. Ancillary Expense		
35	Special Cost Centers	1,733,739	35
36	Provider Participation Fee	166,348	36
	D. Other Expenses (specify):		
37	NET VENDING COSTS	437	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,010,018	40
41	**Income before Income Taxes (line 30 minus line 40)****	776,123	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 776,123	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,034	2,091	$ 83,381	$ 39.88	1
2	Assistant Director of Nursing	3,090	3,378	97,873	28.97	2
3	Registered Nurses	31,244	34,175	903,727	26.44	3
4	Licensed Practical Nurses	44,671	47,095	1,012,443	21.50	4
5	Nurse Aides & Orderlies	161,883	173,898	1,789,337	10.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,787	1,925	22,680	11.78	7
8	Rehab/Therapy Aides	4,428	5,170	73,433	14.20	8
9	Activity Director	1,869	2,163	29,579	13.67	9
10	Activity Assistants	17,350	18,698	188,444	10.08	10
11	Social Service Workers	9,311	9,964	183,918	18.46	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,901	12,769	153,207	12.00	14
15	Cook Helpers/Assistants	37,219	39,623	327,059	8.25	15
16	Dishwashers					16
17	Maintenance Workers	5,999	6,451	76,811	11.91	17
18	Housekeepers	32,017	34,879	314,753	9.02	18
19	Laundry	15,234	16,501	136,003	8.24	19
20	Administrator	1,293	1,319	115,335	87.44	20
21	Assistant Administrator	1,894	2,091	72,044	34.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,200	16,886	351,076	20.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,134	6,838	92,401	13.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	404,558	435,914	$ 6,023,504 *	$ 13.82	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	296	$ 21,558	1-3	35
36	Medical Director	480	36,000	9-3	36
37	Medical Records Consultant	53	2,147	10-3	37
38	Nurse Consultant	1,369	137,583	10-3	38
39	Pharmacist Consultant	88	3,300	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	65	3,705	11-3	44
45	Social Service Consultant	51	2,858	12-3	45
46	Other(specify) PSYCHIATRIC	80	5,000	10-3	46
47	WOUND CARE CONSULTANT	106	7,950	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,588	$ 220,101		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEN RIPSTEIN	ADMIN		$ 115,335
DIANE WALKER	ASST ADMIN		72,044
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 187,379

B. Administrative - Other

Description	Amount
RELATED PARTIES	$ 1,251,359
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,251,359

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		515,314
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 515,314

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 125,440
Unemployment Compensation Insurance		81,239
FICA Taxes		454,471
Employee Health Insurance		445,047
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		0
EMPLOYEE PHYSICAL EXAMS		3,449
PENSION/PROFIT SHARING PLANS		8,408
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 1,118,054

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,143
Health Care Worker Background Check	3,469
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	60,726
TRUST/FRANCHISE/CONTRIB/ETC	9,681
LICENSES & PERMITS	3,809
DUES & SUBSCRIPTIONS	12,932
MGMT CO ALLOCATION	1,560
TRUST/FRANCHISE/CONTRIB/ETC	(9,681)
Less: Public Relations Expense	(31,809)
Non-allowable advertising	(11,650)
Yellow page advertising	(17,267)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,913

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	340
RELATED PARTY	16,378
Seminar Expense	
	8,418
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,136

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINT/DECORATING	06/2001	$	3	$ 298	$ 597	$ 597	$ 298	$	$	$	$	$
2	PAINT/DECORATING	06/2002		3		970	1,939	1,939	969				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$ 298	$ 1,567	$ 2,536	$ 2,237	$ 969	$	$	$	$

Facility Name & ID Number CRESTWOOD CARE CENTRE # 0044164 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL. COUNCIL ON LTC - $18158.40**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,634** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **166,348**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees